COVID

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19

 Preparedness

and Response Plan:

Maldives

**30 June 2020**

Background and Country Context

Country Context

The Republic of Maldives covers about 1192 islands with the population of 515,696 as of 2018. More than 30 percent of the population live in the capital city Male’, while the rest are distributed among 187 geographically dispersed inhabited islands. Basic human development indicators are high. Maldives ranks 101 out of 189 countries in the Human Development Index (HDI) for 2017. Maldives is a middle-income country with gross domestic product (GDP) per capita of US$10,331 (2018)

Fragile ecological profile, low elevation, combined with its economic dependence on limited sectors makes Maldives highly vulnerable to natural disasters and extreme climatic events. The additional challenge of the country’s geography leads to a dispersed population across many small islands, which makes service delivery difficult and can limit opportunities for job creation and economic diversification. Due to increase in the sea surface temperature and ocean acidification process, biodiversity and livelihoods are seriously threatened.

Despite these challenges, Maldives has achieved five out of eight Millennium Development Goals (MDGs), ahead of the 2015 deadline. A strong foundation has been created towards achieving the global Sustainable Development Goals (SDGs). However, considering the unfinished tasks during the MDG period, the socioeconomic and environmental transitional situation of the country poses new challenges in terms of accesses to health services, changing lifestyles, diseases pattern and preventive measures.

Since its introduction tourism has always been a major contributor to the economy making up 28.2% of the GDP in 2013.. The rapid rise in economic standards and living conditions in Maldives over the last three decades has been driven by fast growth in tourism. However, it also makes the Maldivian economy highly vulnerable to fluctuations in global economic turmoil through their effects on tourism and the direct and indirect transmission of these effects to other sectors. The high dependence on tourism, and its economic benefits and risks, are typical of several small island economies. As a country with limited resources, Maldives has a high dependency on imported products. Almost all the products needed for the daily use are imported from abroad with imports on average being 82% higher than the exports.

Health Context

The Ministry of Health (MoH) is mainly responsible for developing the national health policies and strategies, delivering health services, provide public health protection and oversee health regulations to provide quality health services. The health-care delivery system of Maldives is organized into a three tier system, the first being at the island level primary health centres, the second at the higher level of health facilities which include specialty care hospitals (at the atoll level), and tertiary care services at the urban level.

Notable achievements have also been made in the health sector, particularly the increase in life expectancy, improvement of infant, child and maternal health, control of communicable diseases. Despite these achievements, the country is facing newer challenges such as growing rates of noncommunicable diseases (NCDs), accounting for more than 80% of total deaths, demand for better quality services, and heavy reliance on expatriate health professionals, limited health access for the increasing migrant population and being an island nation vulnerability to the impact of climate change.

To address the new health challenges and empower people to lead healthy lives, the Government of Maldives has set an overall national long-term goal to “Enhance health and well-being of the population” in alignment with the global Sustainable Development Goals (SDGs), which has been reflected clearly in its recently developed National Health Master Plan: 2016–2025. The government anticipates to achieve the goal in close collaboration with the health partners focusing on three specific outcomes: (i) build trust in the national health system; (ii) reduce disease and disability among the population; and (iii) reduce inequities in access to health care services and medicines. Priority has been given to develop a people-oriented and accessible health system focusing on good governance and ensuring increased multi-stakeholder participation for disease prevention and quality health service delivery.

There has been rapid cost escalation in recent years, and government health expenditures stand at over 7 percent of GDP and almost 20 percent of the budget, much higher than comparators in the region, among middle income countries (MICs), or other small-island states. The main causes are over-investment in hospitals, high drug prices and a lack of strategic purchasing by the insurance program (“Aasandha”). As a result, health expenditures are a major contributor to overall fiscal imbalances. As it looks towards a future with an aging population and rising burden of NCDs, the sustainability of its health system and its ability to afford human capital investments will be increasingly in doubt unless key system reforms are undertaken. These include hospital management reform (with a focus on the Indira Gandhi Memorial Hospital/ Dharumavantha Hospital the apex hospital in the Maldives), optimizing service delivery with a focus on primary care, procurement and purchasing reform for pharmaceuticals, and modernization of Aasandha’s operations.

Lack of adequately trained local human resources is still a concern, and the sector heavily relies on expatriate health professionals to deliver health services both in the public and private sectors. Counting the large expatriate workforce, the population for every practicing doctor was 447 in 2014 (about the same as in Korea), and the population per practicing nurse was 147 in 2014 (about the same as in Portugal) and close to OECD averages. In 2014, for every 10,000 population there were 9 specialists available.

A Joint External Evaluation (JEE) of the core capacities in the International Health Regulations (IHR) assessed the strengths and weaknesses in Maldives in 2016 and provided a set of recommendations on areas requiring attention in preparedness for an outbreak. These areas included: reviewing existing legislation, especially the completion and enforcement of the Public Health Protection Act for IHR implementation; formulation of a national laboratory framework which embraces policy, guidelines, standard operating procedures (SOPs); and merging of various laws and regulations into one piece dealing with all aspect of food safety, etc. A Health Emergency Operations Plan was prepared in 2018 alongside the existing National Influenza Pandemic Preparedness Plan in 2009. One of the critical initiatives that has emanated from the JEE recommendations and HEOP provisions include the establishment of a National Emergency Operations Centre, which is now fully operational in responding to COVID-19.

COVID19 Context

The COVID-19 pandemic constitutes an unprecedented challenge with very severe health and socio-economic consequences. As of 30 June 2020, there have been 2366 confirmed cases and 9 deaths. 2040 infected have recovered. 309 active cases are being cared at isolation facilities. The Public Health Risk Alert level at national level is level 4 (Red) and at National Level 2 (Yellow). Male city lockdown was announced to respond to community transmission from 16 April and ease out measures have started in Phases. First phase Phase started from 29 May till 14 June and second phase from 15-30 June, 2020. Third phase ease down starts from 1 July 2020 with activities and actions need to be taken as per the new normal and ease out guidelines. Confirmed cases have also been found in Haa Alifu, Uligan, Haa Alifu Thakandhoo, Shaviyani Milandhoo, Shaviyani Narudhoo, Noonu Manadhoo and Kaafu Thulushoo island.

A national public health emergency was declared on March 12, 2020. The situation related to COVID-19 is fluid and these measures are subject to ongoing reviews and changes and daily updates are provided on the government website and COVID dashboard https://covid19.health.gov.mv/en/ The government of Maldives has temporarily suspended issuance of all on-arrival visas effective 00:00 hrs on 27th March 2020. However, all diplomatic personnel from the accredited missions, official delegations from foreign governments, international organizations and agencies are exempted from the restrictions and arrivals would be facilitated in coordination with Ministry of Foreign Affairs as per the guidance from the National Emergency Operation Center. Maldivian nationals and foreign nationals married to Maldivians are allowed entry subject to 14 days quarantine at a place designated by the government upon arrival to the Maldives. The country will be opening borders from 15 July 2020. Tourism will resume in resorts from 15 July 2020 and at island guest hoses from 1 August 2020.

According to the World Bank, The COVID-19 outbreak has had a debilitated effect on tourism, which directly and indirectly accounts for two-thirds of GDP, but also due to suppressed construction activity. Revenues fell by an estimated 23.4 percent in the first quarter of 2020 as tourist-related revenues shrank, whereas spending grew by 10.2 percent. Central government debt rose to an estimated 61.8 percent of GDP in 2019 from 58.5 percent in 2018. Real GDP is expected to contract by 8.5 percent in 2020, 13.9 pp lower than the baseline (pre-COVID-19). This is mostly due to the slump in tourism, which directly and indirectly accounts for two-thirds of GDP, but also due to suppressed construction activity. The government has announced that it is a zero-income country. Government total expenditure on COVID-19 response so far is at USD 63.3 million.

The shock to tourism adversely affects employment and household earnings, as one-third of adult males and a quarter of females are engaged in tourism-related jobs. Lower-income households that depend on fisheries are also affected as exports of raw fish have ceased due to weak demand. The national poverty rate is expected to increase as households close to the poverty line would likely fall into poverty due to the loss of income sources. A larger impact is expected in the atolls, as there is greater dependence on fisheries and the poverty rate was already higher.

The Maldives have been preparing well ahead of the arrival of COVID-19 in close collaboration with the WHO Maldives. The country has elaborated standard operating procedures (SOPs) which are regularly revised by the Technical Advisory Group as per guidance from the WHO. The Ministry of Health (MoH) has a dedicated website to the COVID-19 response with good public information, including access to all key documents related to the COVID-19 response.

Information sharing is very transparent with daily press conferences from the NEOC. Risk communication, community engagement and behavior change activities are being implemented as per the risk communication plan. Given the stage of epidemic that Maldives is in, the most powerful approach to slow the spread is through social distancing hence distancing measures have been put into place including closure of schools, restaurant, religious institution, and café closures which are expected to substantial positive impact, some of which are already in place (e.g., closure of schools, government offices, banks, cinemas, dine-in services in Greater Male, spas except for those in resorts).

With the support of WHO, laboratory capacity has been established in the National laboratory including regular refresher trainings and participation in the External Quality Assurance Programme. WHO has provided 21000 test reactions so far to the country. However, this needs to be expanded to 5 regional covid treatment facilities across the Maldives. Trainings on critical care, IPCC, health care waste management, WASH and trainings of RRT across the country is a continuous process. Procurement of logistics and supplies under all 8 pillars mentioned in the CPRP are essential for the immediate response and continue to be a challenge in the country. WHO has also facilitated participation of national counterparts in the WHO Webinar on Successfully engaging communities in the WHO South-East Asia Region to manage COVID-19 and prevent stigma and discrimination and coordinated with Global IHR network and provided technical guidance for completing Maldives reporting obligations on COVID-19. Continuous technical guidance is provided to the Technical Advisory Committee of the National Emergency Operation Center. Technical and financial support for building capacity of health workforce for COVID-19 response in Critical care training for doctors and nurses for atolls is a crucial element of immediate response as well. GO.Data training for MOH team to strengthen surveillance, contact tracing, data collection, reporting and recording and also to extract data for covid19 Dashboard is also an ongoing process. Support is also needed to ensure continuity of routine health services, essential services and multi partner discussion is critical. Effort is ongoing to ensure country enrolment in the WHO Solidarity trial

The costed Contingency Preparedness and Response Plan (CPRP) is developed in close collaboration with partners based on the eight pillars of the WHO’s global COVID-19 Strategic Preparedness and Response Plan developed with the intent to take stock of the status of preparedness along each of these pillars and identifies gaps. The CPRP has prioritized the following gaps: (i) boosting disease surveillance capacity, including decentralized capacity on two to three locations outside Male’, and diagnostic capacity for COVID-19; (ii) making operational temporary structures to function as quarantine facilities, including at decentralized locations; (iii) equipping health staff with personal protective equipment (PPE) and training them on its use; and (iv) boosting intensive care capabilities, including at decentralized locations (v) Expansion of Essential Health services and (iv) Promoting and protecting health at non health care settings

The following CPRP document is an evolving document, drafted for immediate health needs of the country for short term only. An additional Pillar 9 has been added to capture continuity of essential health services. Even with the existing projections, there is a strong need for multi sectoral collaboration for resource mobilization for health sector and beyond. Even though the CPRP was developed to prepare and respond to the health emergency needs, there is a felt need to include short term, long term actions required to support health, WASH and socio economic sectors to prepare the ground for the recovery as the country will face severe health, environment and economic consequences and as per the World Bank estimates, the Maldives will be the worst affected in the South Asia region

Immediate actions taken

* Health Emergency Operations Plan has been activated and established multi-ministerial/sectoral Health Emergency Coordination (HEOC)
* Country risk assessment was done, and travel restrictions was imposed to/from countries with relatively large number of cases due to ongoing local transmission
* SOPs and screening protocols and suspected management guideline for 2019-nCoV developed
* All arriving passengers are requested to submit Health Declaration Card, including travel history. Thermal scanners are installed to conduct temperature screening in the arriving terminal of PoE
* Strengthened laboratory capacity and mechanisms for sample transfer was established
* Capacity building training for health professionals and points of entry staff
* Strengthened infection prevention and control measures
* PPEs, masks, sanitizers were procurement
* COVID-19 testing capacity was established in the Indira Gandhi Memorial Hospital
* Scaled up risk communication efforts. IEC materials in several languages targeting migrant population have been developed, printed and distributed

preparedness and response actions

Pillar 1: Country-level coordination, planning, and monitoring

**Completed**

* Multi-sectoral Health Emergency Coordination Centre/HECC to support preparedness activated
* National Emergency Operation Centre activated jointly with HPA, MOH, NDMA and other national stakeholders
* NEOC established and supported for all country all society approach
* Risk assessment conducted
* National risk alert levels and actions at each level identified
* Male outbreak response plan developed, table top exercise and drills conducted
* Focal points established for communication at each health facility, at resorts and guest houses
* A National Emergency Preparedness and Response Plan developed
* Lock down plans developed
* Lock down ease out plan developed
* Tourism sector operational plan developed
* School re-opening plan developed

**Actions to be taken**

* Ministry of Health with other relevant stakeholders have been actively working since January 2020 on activities and important activities have been carried out under this theme.
* Technical support of experts in managing community outbreaks and microbiologist
* Formulation of stronger monitoring protocols and leverage technology solutions used in China, South Korea and Singapore to create space for the resuming daily life domestically
* Ensure data collection is disaggregated by sex, age and pregnancy status and are available through the COVID dashboard
* Ensure that Pandemic response plans to include a protection, gender, and inclusion lens to protect the vulnerable groups. (specific focus on elderly, drug users, disabled)
* Monitoring of the effectiveness of the lock down ease out plans

Pillar 2: Risk communication and community engagement

**Completed**

* Awareness sessions conducted to resort staff, frontline health care workers, ports of entry staff, public institutions, migrant workers, community, schools and focused group
* Designated spokesperson identified
* Daily media briefing sessions held
* Dedicated website with updated information of COVID-19 regularly updated
* Dedicated public Viber group created with daily updates, information, public advice and awareness material on COVID-19
* Daily information and awareness messages dispersed through SMS
* Live updates provided to the community on COVID-19 related operations through official Health Protection Agency social media handles
* Information and video spots on COVID-19 displayed through electronic screens and other such media
* Awareness created through local media including TV, Radio & newspapers
* Special door to door information dissemination sessions conducted
* Information dissemination sessions conducted to migrant workers through use of translated IEC materials, phone messages shared to registered migrants phone numbers etc

**Actions to be taken**

* Continuation of awareness & communication sessions for all the relevant stakeholders, focused groups, schools, migrant workers and public institutions with relevant messages targeting different group as per the changing situation.
* Technical support for creation of animations and videography material
* Trainings and orientation on risk communication to MOH/media/MRC etc
* Strengthen risk communication targeting school official to comply with school re-opening guidelines
* Strengthen risk communication targeting people with ease out guidelines and new normal

Pillar 3: Surveillance, rapid response teams, and case investigation

**Completed**

* WHO case definition and updated versions of national COVID-19 guidelines/SOPs shared with all health facilities, points of entry staff and other relevant stakeholders
* Contact tracing capacity strengthened by using dedicated software (GO DATA web portal)
* Relevant reporting and recording forms prepared
* Communication protocol developed for sharing of information from hotline, ports of entry & health facilities, resorts or other sources to core team responsible for contact tracing.
* RRT formed, trained and responding to Male outbreak
* Procurement of hand-held infrared thermometers for institutions, work places and other relevant agencies
* Regular data analysis and dissemination through COVID-19 dash board

**Actions to be taken**

* Strengthening and expansion of contact tracing core team and functions based on changing situation of COVID-19 outside Male
* Capacity building of Central, Regional and Atoll level RRTs

Pillar 4: Points of entry

**Completed**

* Thermal scanners installed at sea ports and airports (domestic and International)
* Handheld cameras provided to ports staff as per surveillance requirement
* Arrival health declaration card submitted by all passengers
* Isolation room established at the main airport
* Awareness session for border health staff, immigration, customs, security and other staff at airports conducted

**Actions to be taken**

* Establishment of thermal screening and isolation rooms at domestic airports
* Continuation of awareness programs to border health staff, immigration, customs, security and other staff at ports.
* Training / refresher for port staff on screening, reporting and personal protection
* Development and adoption of standard operating procedures (SOPs), drawing on international practices for managing entry

Pillar 5: National laboratories

**Completed**

* WHO approved laboratory identified to send samples for testing (first 7 samples sent for testing to Pune, India)
* COVID 19 test kits received with the support of WHO and testing capacity established at central level
* 200 Triple packaging and 15000 UTMs for sample transfer procured and handed over
* Relevant type of PCR available in 2 Regional Hospitals and IGMH
* Infrastructure set up complete with WHO seaport at Addu and Kulhudufushi Hospitals
* Lab staff of Addu and Kulhudufushi trained on COVID-19 diagnosis
* More than 45,000 Primers and probes mobilized for diagnosis
* 5000 GeneXpert COVID-19 Cartridges handed over to MOH through a joint project between WHO And UNDP
* 2 biosafety cabinets handed over

**Actions to be taken**

* Expansion of lab testing capacity at 5 Regional Hospitals - Requires a special panel kit to conduct COVID-19 tests
* Conduct 2-week training program for each batch of laboratory technicians from Regional Hospitals, Police, Hulhumale Hospital & additional staff from IGMH laboratory staff, 3 staff trained from each respective hospital.
* Certification for bio safety cabinets (IGMH)
* Procurement of 40000 RT-PCR kits
* Procurement of 7 GeneXpert machines and 25000 GeneXpert cartridges

Pillar 6: Infection prevention and control

**Completed**

* WHO and national guidelines & SOPS shared with all health facilities, points of entry teams, RRT teams etcetera
* Personal Protective Equipment/PPE provided for all points of entry staff and trained on adequate safety measures
* IPC guideline for schools developed

**Actions to be taken**

* 50000 PPEs to be procured
* Infection control technical support to conduct training and monitoring of health facilities
* Infection control training program in all health facilities and state care institutions
* Procurement of 80 autoclaves with shredders for health facilities for waste management
* Establishing hand washing stations in schools
* Protecting the elderly and people with different abilities

Pillar 7: Case management

**Completed**

* Designated isolation (49 beds) & quarantine facility (12 rooms) established in Farukolhufushi, villivaru
* Designated quarantine facility established in Villivaru (30 rooms), additional quarantine beds at Hulhule Island Hotel designated (136 rooms)
* Designated critical care unit with 10 beds established in Darumavantha Complex
* Additional 5 ICUs (3 CCU, 2 NICU & 1 HDU) at ADK, and 3 HDU at Hulhumale Hospital. One Ventilator available at Hulhumale Hospital
* Quarantine facility for 3000 people and isolation for 2000 developed
* 78 bedded Isolation facility established in Hulhumale
* 200 bedded ICU set up operational at Tree Top Hospital
* Technical Advisory Group/TAG established to provide technical advice for COVID-19 related case management

**Actions to be taken**

* Expansion of isolation facility in 5 zones and in central zone (30 Isolation bed facility in each zone)
* Establishing ICU facilities in 5 zones and in central zone (20 ICUs in 4 each zone and 100 ICUs in central zone)
* Support National Drugs agency, confinement centers and Home of People with Special Needs to prevent and manage COVID-19 infection
* Promote and protect health of residents of Home of People with special needs.
* Expansion of quarantine facilities in each Atoll
* Support to provide drugs, diagnostics and related consumables to operationalize COVID village at Hulhumale
* Health workforce recruitment and development to support exiting gap in health system and to cater for expansion of isolation and ICU facilities
* Refresher program for doctors & nurses on critical care management of respiratory diseases
* Ensure the health facilities being expanded in the islands have safe birth arrangements with adequate resources
* Support Maldives enrollment at Solidarity trail and procure drugs recommended to participate in the trial

Pillar 8: Operational support and logistics

**Completed**

* 70 PPE full Kits received from WHO and 17000 full PPE kits procured through government funding
* 53 items of medicine donated by Indian government (worth 791000 MVR)
* Additional PPE donated by Yunan, China

**Actions to be taken**

* Procurement of additional carrier bags for transfer of samples
* Procurement of PPE kits
* Additional 100,000 UTMs for sample collection
* Additional testing kits and rapid testing kits approved by WHO or USFDA or European Union respective authority

Pillar 9: Maintaining essential health services during an outbreak

**Completed**

* Establishment of triggers/thresholds that activate a prioritization process and phased reallocation of routine comprehensive service capacity towards essential services
* Routine and elective services identified that can be delayed or relocated to non-affected areas
* Establish clear criteria and protocols for targeted referral (and counter-referral) pathways
* Health worker requirements mapped (including critical tasks and time expenditures) in the four COVID-19 transmission scenarios
* Dengue and chikungunya prevention and control and training of doctors to manage these diseases

**Actions to be taken**

* Establish (or adapt) simplified mechanisms and protocols to govern essential health service delivery in coordination with response protocols
* Support protecting the high risk- elderly, cases with NCD, disability and migrants in partnership with other ministries
* Assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways
* Resume EPI services at greater Male as a new normal
* Dengue and chikungunya prevention and control
* Initiate intensification of measles and rubella
* Acuity-based triage ensured at all sites providing acute care
* Generate a country-specific list of essential services (based on context and supported by WHO guidance and tools)
* Redirect chronic disease management to focus on maintaining supply chains for medications and needed supplies, with a reduction in provider encounters

summary of funding requirements and commitment from UN agencies and partners

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Requirements**  |  **Govt**  |  **UNICEF**  |  **UNDP**  |  **UNFPA**  |  **IsDB**  |  **WB**  |  **ADB**  |  **WHO**  | **Others** |  **Total**  |  **Gap** |
| **1. Country-level coordination, planning, and monitoring** |  **3,000,000**  |  **2,000,000**  |  **20,000**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **240,000**  |  |  **2,260,000**  |  **740,000**  |
| **2. Risk Communication and community engagement**  |  **2,500,000**  |  **1,000,000**  |  **265,500**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **113,000**  |  |  **1,378,500**  |  **1,121,500**  |
| **3. Surveillance, rapid response teams, and case investigation** |  **2,500,000**  |  **2,000,000**  |  **-**  |  **-**  |  **-**  |  **-**  |  **300,000**  |  **-**  |  **50,000**  |  |  **2,350,000**  |  **150,000**  |
| **4. Points of Entry /Exit Screening**  |  **1,000,000**  |  **900,000**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **10,000**  |  |  **705,000**  |  **295,000**  |
| **5. National laboratories** |  **4,100,000**  |  **400,000**  |  |  |  |  |  **1,389,091**  |  |  **1,050,000**  |  |  **2,739,091**  |  **1,360,909**  |
| **6. Infection prevention and control** |  **12,000,000**  |  **3,000,000**  |  **899,900**  |  **248,836**  |  **-**  |  |  **401,840**  |  **-**  |  **363,323**  |  |  **4,913,899**  |  **7,086,101**  |
| **7. Case management** |  **30,000,000**  |  **16,500,000**  |  **382,230**  |  **-**  |  **-**  |  **377,075**  |  **4,100,000**  |  **600,000**  |  **1,766,556**  |  |  **23,725,861**  |  **6,274,139**  |
| **8. Operational support and logistics** |  **10,000,000**  |  **4,000,000**  |  |  |  |  |  |  |  **40,000**  |  |  **4,040,000**  |  **5,960,000**  |
| **9. Essential Health Srevices** |  |  **-**  |  **-**  |  **-**  |  **37,000**  |  **-**  |  **-**  |  **-**  |  **400,000**  |  |  **437,000**  |  **(437,000)** |
| **Grand Total** |  **65,100,000**  |  **29,800,000**  |  **1,567,630**  |  **248,836**  |  **37,000**  |  **377,075**  |  **6,190,931**  |  **600,000**  |  **4,032,879**  |  |  **42,549,351**  |  **22,550,649**  |

major activities for support under each pillar

|  |
| --- |
|  |
|  | **Requirements**  |  **Govt**  |  **UNICEF**  |  **UNDP**  |  **UNFPA**  |  **IsDB**  |  **WB**  |  **ADB**  |  **WHO**  | **Others** |  **Total**  |  **Gap** |
| **1. Country-level coordination, planning, and monitoring** |  **3,000,000**  |  **2,000,000**  |  **20,000**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **240,000**  |  |  **2,260,000**  |  **740,000**  |
| Coordination |  3,000,000  |  2,000,000  |  20,000  |  -  |  -  |  -  |  -  |  -  |  90,000  |  |  2,110,000  |  890,000  |
| Management and coordination of response in 6 regions for atleast 3 months  |  |  -  |  -  |  -  |  -  |  -  |  -  |  -  |  50,000  |  |  50,000  |  (50,000) |
| Technical Experts for Lab, Documentation and Training |  |  -  |  -  |  -  |  -  |  -  |  -  |  -  |  100,000  |  |  100,000  |  (100,000) |
| **2. Risk Communication and community engagement**  |  **2,500,000**  |  **1,000,000**  |  **265,500**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **113,000**  |  |  **1,378,500**  |  **1,121,500**  |
| Coordination |  2,500,000  |  500,000  |  160,500  |  -  |  -  |  -  |  -  |  -  |  113,000  |  |  773,500  |  1,726,500  |
| Training & Orientation sessions |  |  500,000  |  105,000  |  -  |  -  |  -  |  -  |  -  |  -  |  |  605,000  |  (605,000) |
| **3. Surveillance, rapid response teams, and case investigation** |  **2,500,000**  |  **2,000,000**  |  **-**  |  **-**  |  **-**  |  **-**  |  **300,000**  |  **-**  |  **50,000**  |  |  **2,350,000**  |  **150,000**  |
| Training & Orientation sessions |  2,500,000  |  2,000,000  |  -  |  -  |  -  |  -  |  300,000  |  -  |  50,000  |  |  2,350,000  |  150,000  |
| **4. Points of Entry /Exit Screening**  |  **1,000,000**  |  **900,000**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **-**  |  **10,000**  |  |  **705,000**  |  **295,000**  |
| Equipment |  1,000,000  |  400,000  |  |  |  |  |  |  |  5,000  |  |  405,000  |  595,000  |
| Monitoring & evaluation |  |  300,000  |  -  |  -  |  -  |  -  |  -  |  -  |  -  |  |  300,000  |  (300,000) |
| Training & Orientation sessions |  |  200,000  |  -  |  -  |  -  |  -  |  -  |  -  |  5,000  |  |  |  -  |
| **5. National laboratories** |  **4,100,000**  |  **400,000**  |  |  |  |  |  **1,389,091**  |  |  **1,050,000**  |  |  **2,739,091**  |  **1,360,909**  |
| IGMH Requirements |  2,000,000  |  300,000  |  |  |  |  |  |  |  50,000  |  |  350,000  |  1,650,000  |
| Police Lab |  100,000  |  100,000  |  |  |  |  |  |  |  |  |  |  100,000  |
| Laboratory setup- Regions |  2,000,000  |  -  |  |  |  |  |  1,389,091  |  |  1,000,000  |  |  2,389,091  |  (389,091) |
| **6. Infection prevention and control** |  **12,000,000**  |  **3,000,000**  |  **899,900**  |  **248,836**  |  **-**  |  |  **401,840**  |  **-**  |  **363,323**  |  |  **4,913,899**  |  **7,086,101**  |
| National Health Requirement List  |  12,000,000  |  3,000,000  |  899,900  |  248,836  |  -  |  |  401,840  |  -  |  363,323  |  |  4,913,899  |  7,086,101  |
| **7. Case management** |  **30,000,000**  |  **16,500,000**  |  **382,230**  |  **-**  |  **-**  |  **377,075**  |  **4,100,000**  |  **600,000**  |  **1,766,556**  |  |  **23,725,861**  |  **6,274,139**  |
| U Bed Setup |  5,000,000  |  1,500,000  |  382,230  |  -  |  -  |  377,075  |  2,100,000  |  600,000  |  250,000  |  |  5,209,305  |  (209,305) |
| Isolation/Quarantine Facilities |  25,000,000  |  15,000,000  |  |  |  |  |  2,000,000  |  |  1,516,556  |  |  18,516,556  |  6,483,444  |
| **8. Operational support and logistics** |  **10,000,000**  |  **4,000,000**  |  |  |  |  |  |  |  **40,000**  |  |  **4,040,000**  |  **5,960,000**  |
| National Health Requirement |  10,000,000  |  4,000,000  |  |  |  |  |  |  |  40,000  |  |  4,040,000  |  5,960,000  |
| **9. Essential Health Services** |  |  **-**  |  **-**  |  **-**  |  **37,000**  |  **-**  |  **-**  |  **-**  |  **400,000**  |  |  **437,000**  |  **(437,000)** |
| Urgent requirements for National Drug Agency (NDA) |  |  |  |  |  |  |  |  |  200,000  |  |  200,000  |  (200,000) |
| Scaling up preparedness of Home for People with Special Needs (HPSN) |  |  -  |  -  |  -  |  -  |  -  |  -  |  -  |  200,000  |  |  200,000  |  (200,000) |
| Ensuring continuation of essential RNMCAH services |  |  |  |  |  37,000  |  |  |  |  |  |  37,000  |  (37,000) |
| Strengthening Mental Health and Psychosocial support services |  |  |  |  |  |  |  |  |  |  |  |  -  |
| **Grand Total** |  **65,100,000**  |  **29,800,000**  |  **1,567,630**  |  **248,836**  |  **37,000**  |  **377,075**  |  **6,190,931**  |  **600,000**  |  **4,032,879**  |  |  **42,549,351**  |  **22,550,649**  |